TERM LIFE INSURANCE POLICY. Benefits payable at the death of the Insured prior to the Policy Expiration Date and while this policy is in force. Renewal premiums payable during continuance of the policy. There is a Conversion Privilege as described in the policy. This policy is non-participating.

This policy is a legal contract between You, as owner(s), and Us, Principal National Life Insurance Company, a stock company. Your policy is issued based on the information in the application and payment of premiums as shown on the current Data Pages. We will pay the benefits of this policy in accordance with its provisions.

EXAMINATION OFFER. IT IS IMPORTANT TO US THAT YOU ARE SATISFIED WITH THIS POLICY. IF YOU ARE NOT SATISFIED, YOU MAY RETURN YOUR POLICY TO EITHER YOUR AGENT OR OUR OFFICE BEFORE THE LATER OF: (1) TEN DAYS AFTER YOU RECEIVE YOUR POLICY OR (2) SUCH LATER DATE AS SPECIFIED BY APPLICABLE STATE LAW. IF YOU RETURN YOUR POLICY, WE WILL REFUND ANY PREMIUM PAID AND YOUR POLICY WILL BE CONSIDERED VOID FROM ITS INCEPTION. PLEASE READ YOUR POLICY CAREFULLY SO YOU MAY BETTER USE ITS MANY BENEFITS.

This policy starts on the Policy Date and will stay in force until the earlier of the Policy Expiration Date shown on the Data Pages or death of the Insured so long as You satisfy the requirements outlined in Your policy.

Secretary

President

TABLE OF CONTENTS

A copy of the application and any additional benefits provided by rider follow the last page of this policy.

Principal National Life
Insurance Company
Des Moines, Iowa 50392-0001

DATA PAGES

Term Life Insurance

POLICY DATA

Policy Number:	4751596
Owner(s):	Matthew Clarence Stewart
Insured's Name:	Matthew Clarence Stewart
Insured's Risk Class:	Preferred Nontobacco
Insured's Age and Gender:	37 - Male
Policy Date:	September 18, 2013
Policy Expiration Date:	September 17, 2071
Face Amount:	$2,000,000
Initial Guaranteed Premium Period:	20 years
Premium:	$1,355.14
Premium Frequency:	Annual

If this policy is adjusted, We will send You new Data Pages. The Data Pages are to be attached to and made a part of this policy. Where new Data Pages conflict with previous Data Pages, the new Data Pages will govern.

Final Conversion Date: September 17, 2033

TABLE OF PREMIUMS

Based on Policy Face Amount

Policy Year	Guaranteed Annual Premium	Policy Year	Guaranteed Annual Premium	Policy Year	Guaranteed Annual Premium
1	$1,355.14	21	$27,395.00	40	$176,595.00
2	1,355.14	22	29,755.00	41	195,635.00
3	1,355.14	23	32,475.00	42	217,875.00
4	1,355.14	24	35,755.00	43	243,555.00
5	1,355.14	25	39,755.00	44	271,555.00
6	1,355.14	26	44,635.00	45	303,435.00
7	1,355.14	27	50,115.00	46	336,635.00
8	1,355.14	28	55,875.00	47	372,435.00
9	1,355.14	29	61,955.00	48	412,075.00
10	1,355.14	30	68,115.00	49	456,355.00
11	1,355.14	31	74,355.00	50	505,435.00
12	1,355.14	32	81,075.00	51	559,035.00
13	1,355.14	33	88,035.00	52	616,475.00
14	1,355.14	34	96,475.00	53	677,075.00
15	1,355.14	35	105,915.00	54	740,315.00
16	1,355.14	36	118,315.00	55	799,795.00
17	1,355.14	37	131,395.00	56	861,795.00
18	1,355.14	38	145,155.00	57	927,195.00
19	1,355.14	39	160,195.00	58	996,275.00
20	1,355.14				

Premiums for any additional riders attached to this policy will be in addition to the premiums shown above.
All premiums shown include an annual policy fee of: $75.00

There is an additional charge for premium frequencies other than annual. This charge is based on the following premium frequency factors:
Semi-annual: .5125 of annual premium
Quarterly: .2625 of annual premium
Pre-Authorized Withdrawal: .0875 of annual premium

Basis of Values: Guaranteed premiums are based on 2001 CSO Mortality Table, age nearest birthday, with distinction for the Insured's gender and tobacco status.

2001 CSO Nonsmoker Mortality Table shall be used for Nontobacco risk class. 2001 CSO Smoker Mortality Table shall be used for Tobacco risk class.

RIDER DATA

SN 3 OR Accelerated Benefits Rider

Effective Date:	September 18, 2013
Maximum Administrative Fee:	$150
Accelerated Benefits Maximum:	$1,000,000

DEFINITIONS IN THIS POLICY

ATTAINED AGE means the Insured's age on the birthday nearest to the Policy Date, plus the number of complete Policy Years that have elapsed since the Policy Date.

EFFECTIVE DATE is the date on which all requirements for issuance of a policy have been satisfied.

FACE AMOUNT is the amount used to determine the death benefit provided by the policy. The Face Amount is shown on the current Data Pages.

INITIAL GUARANTEED PREMIUM PERIOD is as shown on the Data Pages.

INSURED is the person named as the Insured on the Data Pages of the policy. The Insured may or may not be the owner.

MONTHLY DATE is the day of the month which is the same as the day of the Policy Date. The Monthly Date will never be the 29th, 30th, or 31st of any month.

NOTICE is any form of communication We receive in Our office providing the information We need, either in writing or another manner.

POLICY DATE is the date from which Monthly Dates, Policy Years, and policy anniversaries are determined. The Policy Date is shown on the Data Pages. The Policy Date will never be the 29th, 30th, or 31st of any month.

POLICY YEAR is the one year period beginning on the Policy Date and ending one day before the policy anniversary and each subsequent one year period beginning on a policy anniversary.

> Example: If the Policy Date is November 21, 2006, the first Policy Year ends on November 20, 2007. The first policy anniversary falls on November 21, 2007.

WE, OUR, US is Principal National Life Insurance Company.

YOU, YOUR is the owner(s) of this policy.

All other capitalized terms used in this contract but not defined here are found on the Data Pages.

PURCHASING AND KEEPING THE POLICY IN FORCE

PREMIUM PAYMENTS

Your first premium is due on the Policy Date. After that, future premium due dates are determined by the frequency You select.

1. Annual premiums are due on the first day of each Policy Year.
2. Semi-annual premiums are due on the first day of each Policy Year and 6 months thereafter.
3. Quarterly premiums are due on the first day of each Policy Year and every 3 months thereafter.
4. Pre-authorized withdrawal premiums are due on the same day in each month as the Policy Date.

You may change the frequency of the premium payments with Our approval. However, if You choose a premium payment frequency other than annual, an additional charge, as shown on the current Data Page, will apply over and above the guaranteed annual premium.

Premiums are payable when due. All premiums are to be sent to the address We provide in Your premium notice. We will give a receipt to You on request.

We reserve the right to change the premiums on this policy. Any change in the premiums:

1. will be effective on the policy anniversary next following the date We mail the notice to You;
2. will be made on a uniform basis for insureds having the same plan, age at issue, Policy Date, gender, risk class, and tobacco status;
3. will be based on Our future expectations of investment earnings, mortality, persistency, and expenses;
4. will not occur due to any change in risk classification;
5. will not occur more frequently than annually; and
6. will not apply to any riders attached to this policy, unless the rider provides for an increase or decrease in premiums.

TABLE OF PREMIUMS

The guaranteed premium for each Policy Year is shown in the Table of Premiums. For any Policy Year We will not charge an annual premium, excluding rider premiums, greater than the Guaranteed Annual Premium shown in the table for that year.

GRACE PERIOD

Except for the first premium, a grace period of 31 days will be allowed for the payment of each premium. The grace period begins when We mail a Notice of impending policy termination to You. If a premium is not paid when due or within the grace period, it is in default and the policy will terminate effective on the premium due date. We will mail a Notice of impending termination to Your last post office address known to Us.

If the Insured dies during a grace period, We will pay the death proceeds to the beneficiary(ies) subject to the Death Proceeds section of this policy.

TERMINATION

All Your policy privileges and rights under this policy terminate:

1. when the Insured dies; or
2. when the policy expires or is converted; or
3. when the grace period ends as described in the Grace Period provision; or
4. when We receive Your Notice to cancel it.

REINSTATEMENT

If Your policy terminates as described in the Grace Period provision, You may reinstate it provided:

1. Such reinstatement is prior to the Policy Expiration Date as shown on the Data Pages.
2. Not more than three years have elapsed since Your policy terminated.
3. The Insured is alive.
4. You supply evidence which satisfies Us that the Insured is insurable under Our underwriting guidelines then in effect.

5. You pay all past due premiums. We reserve the right to charge interest on past due premiums at 6% compounded annually from their respective due dates.

Reinstatement will be effective on the Monthly Date on or next following the date We approve it. Your Policy Date will remain the original Policy Date. You will receive new Data Pages upon reinstatement.

RENEWAL PRIVILEGE

You may renew this policy without evidence of insurability for successive one year periods for the premium shown in the Table of Premiums on the Data Pages. No period of renewal may extend beyond the Policy Expiration Date shown on the Data Pages.

Renewal will be effective upon payment of the required premium on or before its due date or during the grace period.

CONVERSION PRIVILEGE

Subject to Our approval, this policy may be converted in whole or in part, without evidence of insurability, at any time before the Final Conversion Date shown on Your current Data Pages. The conversion will be allowed provided:

1. this policy is in force;
2. no premium is in default;
3. the Insured is not totally disabled;
4. the Insured's Attained Age is 70 or less; and
5. the Face Amount of the new policy does not exceed the Face Amount of this policy.

THE NEW POLICY

Premiums and values for the new policy will be based on:

1. a risk class most comparable to the risk class of this policy;
2. rates in effect on the date of the conversion; and
3. the Insured's Attained Age on the date of conversion.

The new policy will be any form of life insurance policy, except term insurance, available under Our underwriting guidelines then in effect. The period specified in the Suicide and Incontestability provisions will not begin again for the new policy, and will be measured from the Effective Date of this policy. If the new policy is not accepted, we will restore the Face Amount of Your policy to the Face Amount that existed prior to the conversion.

The date of conversion and the new policy's Effective Date will be the date We approve the Notice for conversion.

RIDERS

Any riders on this policy will cease upon conversion. Similar riders may be issued with the new policy without evidence of insurability subject to the provisions in the new riders and subject to Our rules in effect on the date of conversion. The following conditions must be satisfied:

1. the rider is included in this policy; and
2. the rider is available at the Attained Age of the Insured on the new policy's Policy Date.

DEATH PROCEEDS

We will pay the death proceeds to the beneficiary(ies) in a lump sum, or a benefit option, subject to the provisions of the policy, after We receive Notice and due proof that the Insured died while the policy was in force and prior to the policy expiration date. We require notification of the Insured's death as soon as it occurs, or as soon thereafter as is reasonably possible. Proof of death includes documentation necessary to pay the death proceeds. The death proceeds, determined as of the date of the Insured's death, are A plus B minus C where:

A. is the face amount of this policy as shown on the Data Pages; and
B. is the death proceeds from any benefit rider on the Insured's life; and
C. is any pro rata premium due.

Any premium received after the date of death will be paid to the beneficiary(ies) and will not be included in the calculation of the death proceeds. The death proceeds will be determined without including any premium received after the date of death. With Our consent a different arrangement for return of premium may be specified prior to the payment of death proceeds.

We will pay interest on death proceeds as required by law.

BENEFIT PAYMENT OPTIONS

In lieu of a lump sum payment, You may elect a benefit payment option for payment of the death proceeds. If no benefit payment option has been elected before the Insured's death, the beneficiary may apply the death proceeds to a benefit payment option.

Once the proceeds are applied under a benefit payment option, this policy must be exchanged for a supplementary contract. The Company reserves the right, as its discretion, to provide a supplementary contract issued by itself, by an affiliated company, or by a non-affiliated issuer of annuity contracts.

BENEFIT PAYMENT CONDITIONS

Election of any benefit payment option is subject to the following conditions:

1. Any amount payable to an assignee will be paid in one lump sum. Any remaining proceeds will then be applied to the elected benefit payment option.
2. No changes may be made to the benefit payment option once a supplementary contract is issued.
3. The proceeds applied must be at least $25,000.00.
4. Benefit payment options are restricted if the recipient of benefits is not a natural person.
5. We reserve the right to require evidence of age, gender where applicable, and continuing survival.
6. Under Options B, C, D, and E, one of the persons on whose life payments are based must be the owner, Insured, or beneficiary.

DESCRIPTION OF BENEFIT PAYMENT OPTIONS

OPTION A, CUSTOM: A custom benefit arrangement can be designed with the Company's written approval.

OPTION B, LIFE INCOME: We will make benefit payments during the person's lifetime. Payments cease when the person dies. Payments will be in an amount We determine but not less than guaranteed by this section.

OPTION C, LIFE INCOME WITH GUARANTEED PERIOD: We will make benefit payments for the longer of the person's lifetime or a guaranteed period that You select. Payments will be in an amount We determine but not less than guaranteed by this section. The guaranteed minimum monthly life income for an elected 10-year guaranteed period is shown in Option C Table below. If the person dies after payments begin but before the end of the guaranteed period, the remaining payments will be paid to the named beneficiary(ies) under the benefit payment option.

OPTION D, JOINT AND SURVIVOR LIFE INCOME: We will make benefit payments during the lifetime of two persons. Payments cease when both persons have died. Payments will be in an amount We determine but not less than guaranteed by this section.

OPTION E, JOINT AND SURVIVOR LIFE INCOME WITH GUARANTEED PERIOD: We will make benefit payments for the longer of the lifetimes of two persons or a guaranteed period that You select. Payments will be in an amount We determine but not less than guaranteed by this section. The minimum monthly joint and 100% survivor life income for an elected 10-year guaranteed period is shown in the OPTION E TABLES below. If both persons die after payments begin but before the end of the guaranteed period, the remaining payments will be paid to the named beneficiary(ies) under the benefit payment option.

BENEFIT OPTIONS B, C, D, and E: These benefit options are based on the Annuity 2000 Mortality Table with mortality projected 40 years by projection Scale G and 3.0% interest. Payments will be in an amount We determine but not less than guaranteed by this section. Benefit options are also based on the gender of the payee.

OPTION B TABLES

These tables show the minimum monthly life income for each $1,000 of proceeds applied. We will make the first payment on the effective date of the supplementary contract.

Age of Male Payee	Life Income
55	4.03
56	4.10
57	4.18
58	4.25
59	4.33
60	4.42
61	4.51
62	4.61
63	4.71
64	4.82
65	4.94
66	5.07
67	5.20
68	5.35
69	5.50
70	5.66
71	5.83
72	6.01
73	6.19
74	6.40
75	6.61
85	9.75
95	15.68

Age of Female Payee	Life Income
55	3.78
56	3.84
57	3.90
58	3.96
59	4.03
60	4.10
61	4.17
62	4.25
63	4.34
64	4.43
65	4.52
66	4.63
67	4.74
68	4.85
69	4.98
70	5.11
71	5.25
72	5.41
73	5.57
74	5.75
75	5.94
85	8.84
95	14.27

OPTION C TABLES

This table shows the minimum monthly life income for an elected 10-year guaranteed period for each $1,000 of proceeds applied. We will make the first payment on the effective date of the supplementary contract.

Age of Male Payee	10-Year Guaranteed Period	Age of Female Payee	10-Year Guaranteed Period
55	4.01	55	3.77
56	4.08	56	3.82
57	4.15	57	3.88
58	4.22	58	3.94
59	4.30	59	4.01
60	4.38	60	4.08
61	4.46	61	4.15
62	4.55	62	4.23
63	4.65	63	4.31
64	4.75	64	4.39
65	4.85	65	4.48
66	4.96	66	4.58
67	5.08	67	4.68
68	5.20	68	4.79
69	5.32	69	4.90
70	5.46	70	5.02
71	5.59	71	5.15
72	5.73	72	5.28
73	5.88	73	5.42
74	6.03	74	5.57
75	6.18	75	5.72
85	7.88	85	7.53
95	9.19	95	9.01

OPTION D TABLES

These tables show the minimum monthly joint and 100% survivor life income for each $1,000 of proceeds applied. We will make the first payment on the effective date of the supplementary contract.

Age of Male Payee	Age of Female Payee							
	55	60	62	65	70	75	85	95
60	3.58	3.75	3.81	3.91	4.05	4.17	4.33	4.39
62	3.61	3.79	3.86	3.97	4.14	4.29	4.49	4.57
65	3.65	3.85	3.94	4.07	4.28	4.48	4.76	4.88
70	3.69	3.94	4.04	4.21	4.51	4.80	5.27	5.52
75	3.73	4.00	4.12	4.32	4.69	5.10	5.86	6.32
85	3.76	4.06	4.21	4.45	4.95	5.58	7.11	8.46
95	3.77	4.09	4.24	4.50	5.06	5.82	8.08	10.90

OPTION E TABLES

These tables show the minimum monthly joint and 100% survivor life income with and elected 10-year guaranteed period for each $1,000 of proceeds applied. We will make the first payment on the effective date of the supplementary contract.

Age of Male Payee	Age of Female Payee							
	55	60	62	65	70	75	85	95
60	3.58	3.75	3.81	3.91	4.05	4.17	4.31	4.37
62	3.61	3.79	3.86	3.97	4.14	4.29	4.47	4.54
65	3.65	3.85	3.94	4.07	4.28	4.47	4.73	4.83
70	3.69	3.93	4.04	4.21	4.50	4.78	5.22	5.41
75	3.72	3.99	4.11	4.31	4.68	5.08	5.76	6.10
85	3.76	4.05	4.20	4.44	4.92	5.51	6.79	7.62
95	3.77	4.07	4.22	4.48	5.01	5.69	7.38	8.70

OWNER, BENEFICIARY, ASSIGNMENT

OWNER

The owner(s) is as named in the application unless You change ownership as provided in the Change of Owner Or Beneficiary provision. As owner(s), You may exercise every right and privilege provided by Your policy, subject to the rights of any irrevocable beneficiary(ies). Your ownership rights and privileges continue while Your policy is in force. If an owner dies before the policy terminates, the surviving owner(s), if any, shall succeed to that person's ownership interest, unless otherwise specified. If all owners die before the policy terminates, the policy will pass to the Insured. With Our consent You may specify a different arrangement for contingent ownership.

BENEFICIARY

The beneficiary(ies) named in the application will receive the death proceeds unless You change the beneficiary designation as provided in the Change of Owner Or Beneficiary provision. If any beneficiary dies before the Insured, We will pay the death proceeds to any surviving beneficiary(ies) according to terms of the beneficiary designation then in effect. If no beneficiary(ies) survives the Insured, the death proceeds will be paid to the surviving owner(s) in equal percentages or, if applicable, to the last surviving owner's estate unless otherwise specified.

CHANGE OF OWNER OR BENEFICIARY

You may change the owner(s) or beneficiary(ies) of this policy by sending Us Notice. Once We accept the Notice, the change is effective as of the date You signed the request. We may require that You send Us this policy so We can record the change.

BENEFIT INSTRUCTIONS

While the Insured is alive, You may send Us instructions for the payment of the death proceeds under one of the benefit payment options. Such instructions, or change of instructions, must be in a format We specify. We must approve the arrangement chosen before any payment is made. If You change beneficiary(ies), prior benefit instructions are revoked.

ASSIGNMENT

You may assign Your policy as collateral for a loan by providing Us with an original or a certified copy of the assignment which must be in a form acceptable to Us. We assume no responsibility for the assignment's validity. An assignment does not change the ownership of the policy. The rights of beneficiaries, whenever named, except for irrevocable beneficiaries named prior to Our notice of the assignment, become subordinate to those of the assignee. The assignment becomes effective on the date We receive it and is subject to any action taken by Us prior to that date.

GENERAL INFORMATION

ADJUSTMENTS

The policy Face Amount may be decreased as a result of a partial conversion. You may request a risk class change subject to Our underwriting guidelines then in effect.

THE CONTRACT

This policy, the attached application(s) and riders or endorsements, any amendments to the application(s), any adjustment and reinstatement application(s), and the current Data Pages make up the entire contract. Any statements made in the application(s), adjustment application(s), reinstatement application or any amendments to the application(s) will be considered representations and not warranties. No statement, unless made in an application(s), or amendments thereto, will be used to void Your policy (or void an adjustment in case of an adjustment application(s)) or to defend against a claim.

ALTERATIONS

This policy may be altered by mutual agreement, but any alterations must be in writing and signed by one of Our corporate officers. No one else, including the agent, may change the contract or waive any provisions.

INCONTESTABILITY

With respect to statements made in the initial application(s) for this policy, We will not contest this policy after the policy has been in force during the lifetime of the Insured for two years from the Policy Date. With respect to statements made in any subsequent application(s) or reinstatement application(s), We will not contest the coverage resulting from such application(s) after the coverage has been in force during the lifetime of the Insured for two years after the date of the change.

MISSTATEMENT OF AGE OR GENDER

If the age or gender of the Insured has been misstated, the death benefit will be the amount the premium would have purchased at the correct age or gender of the Insured.

SUICIDE

This policy's death proceeds will not be paid if the Insured dies by suicide, while sane or insane, within two years of the Policy Date. Instead, We will return all premiums paid. This amount will be paid to the beneficiary(ies).

BASIS OF VALUES

Guaranteed premiums are based on the mortality table referred to on the Data Pages.

Where required, We filed a detailed statement of the method of calculating benefits with the insurance department of the state in which this policy is delivered. The guaranteed benefits are greater than or equal to those required by any state law.

ACCELERATED BENEFITS RIDER

This rider is part of Your policy. All policy definitions, provisions, and exceptions apply to this rider unless changed by this rider. The Effective Date of this rider is the same as the Policy Date unless another date is shown on the Data Pages.

BENEFIT

We will pay an accelerated benefit if the Insured is terminally ill, subject to the provisions of this rider. The maximum accelerated benefit You may receive is the lesser of:

1. The Accelerated Benefits Maximum shown on the Data Pages; or
2. 75% of the Face Amount of the policy minus any previously paid accelerated benefit.

We will pay the accelerated benefit as a lump sum. The minimum amount of any payment is $500.00. We may charge a one time administrative expense fee up to the maximum which is shown on the Data Pages.

INTEREST CHARGE

We charge interest on the amount of the accelerated benefit. The interest accrues daily at the annual interest rate of 8%. On the policy anniversary, the accrued interest will be added to the accelerated benefit amount. Additional interest will not accrue if the accelerated benefit amount plus accrued interest equals the Face Amount of the policy.

EFFECT ON YOUR POLICY

The accelerated benefit amount plus its accrued interest will be treated as a lien against the policy. Death proceeds, as defined in the policy, will be reduced by the amount of the accelerated benefit amount plus accrued interest. Premiums due on any remaining death benefit under this policy will be waived.

Any benefits payable under riders attached to Your policy are not affected by any benefit paid under this rider.

PROOF OF TERMINAL ILLNESS

To be considered terminally ill under this rider, the Insured must have a medical condition which would in the absence of extensive or extraordinary medical treatment; result in a drastically limited life span and is expected to die within 12 months of the date payment of an accelerated benefit amount is requested.

We will pay an accelerated benefit amount to You after We receive Notice and proof satisfactory to Us that the Insured is terminally ill. Proof will consist of:

1. a completed claim form;
2. a statement from a licensed physician, who is not yourself or a member of Your family, and
3. any other medical information that We believe necessary to confirm the Insured's status. This may include Our right to obtain a second medical opinion at Our expense.

CLAIMS

You may request an accelerated benefit amount by sending Us Notice. Upon receipt of Your Notice, We will provide a claim form within 10 working days.

CONDITIONS

The payment of any accelerated benefit amount is subject to the following conditions:

1. The policy must be in force.
2. The policy must not be assigned as security for a loan.
3. The payment of an accelerated benefit amount must be approved by any irrevocable beneficiary.
4. This rider provides for the accelerated payment of the death proceeds of Your policy. This is not meant to cause You to involuntarily access proceeds ultimately payable to the beneficiary. Therefore, You are not eligible for this benefit:
   a. If You are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
   b. If You are required by a government agency to use this benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement.

TERMINATION

This rider ends on the first of:

1. The termination of Your policy; or
2. Our receipt of Your Notice to cancel this rider. We may require You to send Your policy to Our office to record the cancellation.

REINSTATEMENT

This rider may be reinstated as part of Your policy.

President

Principal National Life Insurance Company
Des Moines, Iowa 50392-0001

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Principal Financial Group

☐ Principal Life Insurance Company
☐ Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

Life Insurance Application

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

PART A

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex	Date of Birth
MATTHEW CLARENCE STEWART	☒ Male ☐ Female	03/20/1976
Primary Residence Street Address	**Social Security Number**	**Birthplace (State, or Country if not U.S.)**
17581 S. FIRESTONE CT.	542-06-3110	OREGON
City, State, Zip Code	**Driver's License Number**	**State Issued**
OREGON CITY, OR 97045	5333605	OR
Home Phone Number	**Occupation**	
(503) 957-0864	BUSINESS OWNER	
Work Phone Number	**Workplace Zip Code**	
(503) 235-1485	97206	

2. BASIC COVERAGE APPLIED FOR

Product 20 YEAR TERM

Face Amount (excluding riders)
$ 2,000,000

Death Benefit Option if applicable:
- ☐ Option 1: Level Face Amount
- ☐ Option 2: Face + Accumulated/Policy Value
- ☐ Option 3: Face + Premiums Paid Less Partial Surrenders

Policy Planned Premium $ 1,068.00

Premium Frequency: (choose one)
☒ Annual ☐ Semi Annual ☐ Quarterly ☐ Single Pay

☐ EFT (complete EFT form + attach sample check)

List Bill Number _____
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly

Unscheduled Premium $ _____

3. BENEFITS/RIDERS (Some riders are not available with all products)

- ☐ Accidental Death – Amount $ _____
- ☐ Accounting Benefit
- ☐ Alternate Cash Surrender Value
- ☐ Change of Insured
- ☐ Children Term – Amount $ _____
- ☐ Four Year Term
- ☐ 20 Year Premium Guarantee
- ☐ Policy Split Option
- ☐ Salary Increase – Amount $ _____
- ☐ Single Life Term – Amount $ _____
- ☐ Waiver of Premium/Specified Premium
- ☐ Waiver of Monthly Deductions/Monthly Policy Charges
- ☐ _____
- ☐ _____

4. BENEFICIARY INFORMATION

Primary Beneficiary	Relationship to Proposed Insured
BRITTANY STEWART	WIFE
Contingent Beneficiary	**Relationship to Proposed Insured**
ESTATE OF THE INSURED	
Single Life Term Rider Beneficiary	**Relationship to Proposed Insured**

Proposed Insured Name _____

5. OWNERSHIP INFORMATION (Complete if different than the Insured)

Owner Name (If trust, provide name of trust*)	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth (If trust, provide date of trust*)
Joint Owner Name	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Contingent Owner Name	Relationship to Proposed Insured

*** Submit copy of trust with this application.**

6. CHANGE OF OWNERSHIP

(a) Is there an intention that any group of investors will obtain any right, title, or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application? ☐ Yes ☒ No
If yes, explain. _____

(b) Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you in return for an assignment of policy values back to them? ☐ Yes ☒ No
If yes, explain and complete premium financing acknowledgment form. _____

7. OTHER INSURANCE

(a) Is there other life insurance or annuities in force or applied for? ☐ Yes ☒ No
(If yes, list all other life insurance or annuities in force or currently being applied for, even if sold, assigned, or viaticated.)

Insured's Name	Company	Amount	Policy Number	Check if Pending	Year Issued	Primary Purpose
		$		☐		
		$		☐		
		$		☐		
		$		☐		

(b) If coverage is pending, will all pending coverage be accepted? ☐ Yes ☒ No
If no, explain. _____

(c) Have you transferred or assigned any right, title, or interest in any life insurance or annuity contract other than absolute assignment for Internal Revenue Code 1035 exchange? ☐ Yes ☒ No
If yes, explain. _____

8. REPLACEMENT

(a) Will the insurance applied for with this application replace or affect any of the owner's other life or annuity contracts (including pending coverage provided with a binding receipt)? ☐ Yes ☒ No
If yes, list company name(s) and policy number(s) and provide necessary forms:

_____

_____

(b) Is this an Internal Revenue Code section 1035 exchange? ☐ Yes ☒ No

Proposed Insured Name MATT STEWART

9. MEDICAL QUESTION

Within the last ten years, has the Proposed Insured been treated for, or diagnosed as having a heart condition, chest pain, stroke, cancer, diabetes, alcohol abuse or drug dependency? ..... ☐ Yes ☒ No
(If yes, explain below.)

Details (including dates and healthcare provider's name/address)

(Continue to next page)

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Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

Insurance Application

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Proposed Insured MATTHEW STEWART
D.O.B. 03 / 20 / 1976 Policy Number (If known) _____

PART B
All references to "you" mean the Proposed Insured.

ACTIVITIES/HEALTH HABITS

1. In the last five years have you, or do you have plans to:
   a. be a member of any armed forces or military unit? ☐ Yes ☒ No
   b. pilot any type of aircraft? ☐ Yes ☒ No
   c. engage in scuba/skin diving, motor vehicle racing, skydiving or any other hazardous sporting activity? ☒ Yes ☒ No
   d. live outside the United States or Canada? (If yes, explain below) ☐ Yes ☒ No
   e. travel outside the United States or Canada? (If yes, explain below) ☐ Yes ☒ No
2. In the last five years have you:
   a. been in a motor vehicle accident, been charged with driving while intoxicated or had more than one moving violation? (If yes, explain below) ☐ Yes ☒ No
   b. been on parole or probation or charged with a felony or misdemeanor? (If yes, explain below) ☐ Yes ☒ No
3. In the last ten years have you used any tobacco or nicotine products? ☐ Yes ☒ No
   (Indicate date last used and amount per day)
   a. ☐ cigarettes _____ d. ☐ pipe _____
   b. ☐ cigars _____ e. ☐ chewing tobacco/snuff _____
   c. ☐ nicotine patch/gum _____ f. ☐ other _____
4. In the last ten years have you consumed alcoholic beverages? ☒ Yes ☐ No
   If yes, date last used? 4/21/2018 Number of drinks per week: 2
5. In the last ten years have you used cocaine, marijuana, methamphetamines, barbiturates or other controlled substances? ☐ Yes ☒ No
6. Have you ever been advised to limit or discontinue the use of alcohol or drugs; or sought or received treatment because of your alcohol or drug use? ☐ Yes ☒ No

DETAILS TO QUESTIONS 1-6

Quest. #	Include dates and details as requested above.

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Proposed Insured MATTHEW STEWART
D.O.B. 3 / 20 / 1976 Policy Number (If known) _____

PART B – (Continued)

INCOME/OCCUPATION
For Life, complete questions 7 and 8. For DI, complete questions 8-17. In all cases, Part B continues on the next page.

7. Annual income from occupation $ 300,000 Other Income $ $24,000
   Source of other income RENTAL OF MILWAUKIE Net Worth (Assets – Liabilities) $ 1,000,000 w
8. Primary occupation BUSINESS OWNER Employer SELF
9. Current Employment Information
   a. Type of business or industry AUTOMOTIVE REPAIR
   b. Job title OWNER
   c. What are your job activities and percentage of time spent in each? MARKETING 20% BOOKS 20% MANAGING STORES 60%
   d. How many hours do you usually work per week in your primary job? 30
   e. Total number of employees: Full-time 16 Part-time 0 Sub-contracted 0
   f. How many employees do you supervise? 16
10. How long have you been employed by your current employer? 7 YEARS (If less than three years, provide details below, e.g., employers, occupations and dates for last five years.)
11. Do you work out of your home? (If yes, how many hours per week? 10) ☒ Yes ☐ No
12. Do you have any other part-time or full-time jobs? (If yes, explain below) ..... ☐ Yes ☒ No
13. Are you actively at work on a full-time basis without medical restriction? (If no, explain below) ..... ☒ Yes ☐ No
14. Do you intend to change jobs or employment in the next 6 months? (If yes, explain below) ..... ☐ Yes ☒ No
15. Have you ever requested or received any type of disability benefits (including workers' compensation and state disability) for an injury or illness? (If yes, explain below)..... ☐ Yes ☒ No
16. Do you have an ownership interest in any business you work for? ..... ☒ Yes ☐ No
    If yes, ownership percentage 100 length of ownership 7 YEARS
    Type of business: ☐ C Corporation ☒ S Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Limited Liability Company ☐ Other _____
17. Have you, or any business owned in whole or part by you, ever been in bankruptcy or any similar proceedings? (If yes, provide date discharged, type and chapter)..... ☐ Yes ☒ No

DETAILS TO QUESTIONS 7-17

Quest. #	Include dates and details as requested above.

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Proposed Insured MATTHEW STEWART
D.O.B. 3 / 20 / 1976 Policy Number (If known) _____

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 18-20 below)

18. In the last ten years, have you had, been treated for or been diagnosed as having:
    a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, or any other disease or disorder of the heart or blood vessels? ☐ Yes ☒ No
    b. cancer or a tumor, cyst or growth? ☐ Yes ☒ No
    c. asthma, bronchitis, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system? ☐ Yes ☒ No
    d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system? ☐ Yes ☒ No
    e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder? ☐ Yes ☒ No
    f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? ☐ Yes ☒ No
    g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? ☐ Yes ☒ No
    h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system? ☐ Yes ☒ No
    i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, or any other disease or disorder of the bones, joints, or muscles? ☐ Yes ☒ No
    j. any disease or disorder of the eyes, ears, nose, throat or skin? ☐ Yes ☒ No
19. (DI Only) Are you currently pregnant or have you had complications of pregnancy in the last ten years? ☐ Yes ☒ No
20. In the last ten years, have you had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)? ☐ Yes ☒ No

DETAILS TO QUESTIONS 18-20

Quest. #	For yes answers, include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address.

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Insurance Application

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Proposed Insured _____

D.O.B. ____ / ____ / _____ Policy Number (If known) _____

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 21-26 below)

21. Who is your Primary Physician? ☐ None 503-656-5273

a. Name: DR. KAI LI | Street: 10011 MOLALLA AVE | City: OREGON CITY | State: OR | Zip: 97045 | Phone Number: OR 97045

b. Date last seen, reason and details: BAR INFECTION 2012

22. In the last ten years:

a. have you had any medical tests, hospitalization, illness or injury not provided in response to a previous question? (If yes, explain below) ☐ Yes ☒ No

b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? (If yes, explain below) ☐ Yes ☒ No

23. Are you taking or have you been advised to take any medication or treatment not provided in response to a previous question? (If yes, explain below) ☐ Yes ☒ No

24. Current Ht. 6'2" Wt. 200 Have you lost more than 10 lbs. in the last year? ☐ Yes ☒ No
If yes, _____ lbs./kgs. Indicate reason _____

25. a. Has either of your natural parents lived to at least age 60? ☒ Yes ☐ No

b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? ☐ Yes ☒ No
If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death):

26. Have you ever had any life, health or disability insurance rated, ridered or declined? (If yes, explain below) ☒ Yes ☐ No

DETAILS TO QUESTIONS 21-26

Quest. #	Include dates and details as requested above.
	2 YEARS AGO APPLIED AND APROVED BUT DECLINED
	PURCHASE DUE TO RATING AND COST.

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Life Insurance Application

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PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

AGREEMENT

Statements In Application: I represent that all statements in this application are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I understand and agree that the statements in the application, including statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, shall be the basis of any insurance issued. I also understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued as applied for with a premium deposit paid, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner and signing of Part D, if applicable.

I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no policy liability unless:

1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
2) At the time of such delivery and payment, the person to be insured is actually in the state of health and insurability represented in this application, medical questionnaire, or amendment that becomes a part of this application; and
3) The Part D or the Acknowledgment of Delivery form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application and on any medical questionnaire that becomes a part of this application may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

If my employer is the owner and beneficiary on this application: I agree to allow my employer to purchase insurance on my life. I understand that my employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy. There is no obligation, on my part, to pay the policy premiums. The corporation, employer or trustee has provided grounds for insurable interest on me. I understand and agree that my administrators, estate, heirs and assignees have no rights to the policy or any policy proceeds. I understand that the maximum face amount for which I could be insured at the time of issuance is generally not more than 30 times compensation, up to a maximum of $30,000,000, subject to underwriting guidelines. I further authorize my employer or trustee to increase or decrease the amount of insurance on my life in the future without another consent from me and without further notice to me as long as I am employed by the employer. I consent to and authorize my employer, trustees, or its successors to continue to be the owner and beneficiary of this policy(ies) indefinitely including after the end of my employment by the employer.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I agree that this authorization shall be valid for 24 months from the date of this application. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc.

C.O.D. or Advance Premium Paid:

☐ This application is C.O.D. and I have not been given any Conditional Receipt with this application.

☒ I have paid $ 1,068.00 as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.

☐ I have submitted an Absolute Assignment form with this application and I have been given the Life Insurance 1035 Conditional Receipt. In return I have read, understand, and agree to its terms.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Signatures – Please read all of the above Agreements, Authorizations, and Certification before signing below.

Signature of Proposed Insured (If age 15 or over) X Matthew Stutt				
Signature of Parent (If Proposed Insured is under age 18 and Parent has not signed as Owner) X				
Signature of Owner(s), if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.				
X			Title	
X			Title	
X			Title	
Signed at: City Oregon City	State OR	Date 7-31-13	Signature of Licensed Agent/Broker/Representative X Brian L. Vik	License Number
Cosignature by resident Licensed Agent/Broker/Representative, if applicable in your state X			Date	License Number

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Medical Questionnaire

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Print full name of Proposed Insured: MATTHEW C. STEWART

Date of Birth (Month/Day/Year): 03-20-1976

	Yes	No
1. In the last ten years, have you had, been treated for or been diagnosed as having:		
a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, anemia, or any other disease or disorder of the heart or blood vessels?	☐	☒
b. cancer or a tumor, cyst or growth?	☐	☒
c. asthma, bronchitis, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system?	☐	☒
d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system?	☐	☒
e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder?	☐	☒
f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract?	☐	☒
g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system?	☐	☒
h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system?	☐	☒
i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, fibromyalgia, or any other disease or disorder of the bones, joints, or muscles?	☐	☒
j. any disease or disorder of the eyes, ears, nose, throat or skin?	☐	☒
2. (DI Only) Are you currently pregnant or have you had complications of pregnancy in the last ten years?	☐	☒
3. In the last ten years, have you had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?	☐	☒
4. In the last ten years:		
a. have you had any medical tests, hospitalization, illness or injury not provided in response to a previous question?	☒	☐
b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question?	☐	☒
5. Are you taking or have you been advised to take any medication or treatment not provided in response to a previous question?	☐	☒
6. Have you lost more than 10 lbs. in the last year?	☐	☒
If yes, ____ lbs./kgs. Indicate reason. ____		
7. a. Has either of your natural parents lived to at least age 60?	☒	☐
b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death)	☐	☒
8. Have you ever had any life, health or disability insurance rated, ridered or declined? (If yes, provide details)	☐	☒

DETAILS TO QUESTIONS 1-8

For "yes" answers to questions 1-6 include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address. (if additional space needed, attach a separate page that is completed, witnessed, signed, and dated)

Quest. #	
4A	Chin laceration 2009 sutured-Resolved Providence Urgent Care 200 S. Hazel Dell Way Canby, OR

Medical Questionnaire, continued

9. Who is your Primary Physician? ☐ None

a. Name Dr. Kia Lie Phone Number 503-656-5273

Street 1001 Molalla Ave City Oregon City, State OR Zip 97045

b. Date last seen, reason and details

2013 ear infection - antibiotics - Resolved

I have read the statements and answers recorded above; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Signature of Proposed Insured X [signature] Date 08-06-2013 Signature of Witness/Title X Stephanie Crawford CMA

PHYSICAL MEASUREMENTS RECORDED BY EXAMINER

10. a. Height (in Shoes) feet 6 in. 1 1/2 ; or cm
b. Weight (Clothed) pounds 202 ; or kg
c. Did you weigh? ☒ Yes ☐ No Did you measure? ☒ Yes ☐ No
d. Chest (Full Inspiration) in./cm. 41
Chest (Forced Expiration) in./cm. 36 3/4
Abdomen, at Umbilcus in./cm. 32

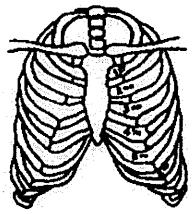
11. Blood Pressure in sitting position:

	First Reading	Second Reading	Third Reading
Systolic/ Diastolic	112/70	104/68	100/66

12. Pulse:

	At Rest
Rate	76
Irregularities per min.	0

13. Heart: is there any:
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below)
Location
☐ Constant ☐ Inconstant ☐ Transmitted ☐ Localized ☐ Systolic ☐ Diastolic ☐ Soft (Gr. 1-2) ☐ Mod. (Gr. 3-4) ☐ Loud (Gr. 5-6)
Indicate: Apex by X; Murmur area by ◯; Point of greatest intensity by ◯; Transmission by →



14. Is there any abnormality of the following (circle applicable items and give details) on examination:

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (incl. scars); lymph nodes; varicose veins; peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system (include prostate)?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
15. (a) Are there any hernias?	☐	☐
(b) Any hemorrhoids?	☐	☐
16. Are you aware of additional medical history?	☐	☒

Give details to "Yes" answers:

Name of agent soliciting application: BRIAN VIK

Examination made at: ☐ Examiner's Office ☒ Applicant's Home ☐ Other

Examiner (print name) S. CRAWFORD, CMA M.D./D.O./Para Med.

Exam Company Name / APPS PARAMEDICAL 038

Exam Company Address 9950 Southwest 105th Avenue Beaverton, Oregon 97008-5421 (503) 906-1866

Signature of Examiner X Stephanie Crawford CMA

Send exam to Home Office only.

AA 672 N

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Medical Questionnaire

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Print full name of Proposed Insured	Date of Birth (Month/Day/Year)
MATTHEW C. STEWART	03-20-1976

Quest. #	Include dates and details as requested.

Signature of Proposed Insured	Date	Signature of Witness/Title
X [signature]	08-06-2013	X Stephanie Crawford

Matt Stewart

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Application Supplement

SPORT STATEMENT

Check type of sport and answer questions.

RACING – Check one type only on this form. If you have in the past or now engage in different types of racing, please fill out one form for each type.

- Automobile
- Stock car
- Championship
- Drag
- Sports car
- Sprint
- Go-Kart
- Other
- Motorcycle
  - ☐ Hill climbing
  - ☐ Enduro
  - ☐ Drag
  - ☐ Flat track
  - ☐ Moto cross
  - ☐ Other
- Motor boat
- Snowmobile

1. Number of races in last 12 months 1 One to two years ago 0
   Lifetime 1 Plan to in the next 12 months 1
2. Date of last race 6/22/13
3. Make and type of vehicle 2007 CHEVY CORVETTE
   formula and / or engine displacement 6 LITER
4. Top speed 110 MPH Average speed 75 Usual distance of race 2 MILE
5. Do you compete for cash prizes? ☐ Yes ☒ No
6. Cities / towns where you race PORTLAND KIHA PERFORMANCE DRIVING, NOT RACING NO PASSING IS ALLOWED
7. Describe track (layout and surface) 1.9 MILE ASPHALT TRACK W/ 12 TURNS
8. Vehicle class NOVICE
9. Organization(s) which sanctions your races SCCA
10. Do you plan to do any other type of racing? ☐ Yes ☒ No If "Yes", give details

- Scuba
- Skin diving

1. Number of dives in last 12 months 1 One to two years ago 1
   Lifetime 3 Plan to in next 12 months 0
2. Date of last dive 10/3/13
3. How deep usually 30-60 FEET Deepest dive 80 FEET
   In last year how many times below 30 feet 60 feet 75 feet 100 feet
4. Location(s) ☒ Ocean ☒ Lake ☐ River ☐ Other
5. National organization(s) you are certified with PADI
6. Describe equipment used SCUBA OR STANDARD TANK WITH WET SUIT
7. Do you, or do you plan to dive for pay? ☐ Yes ☒ No If "Yes", give details

- Sky diving

1. Number of jumps in last 12 months _____ One to two years ago _____
   Lifetime _____ Plan to in next 12 months _____
2. Date of last jump _____
3. Minimum height chute has opened _____
4. Reserve chute used? ☐ Yes ☐ No
5. National sky diving member? ☐ Yes ☐ No
6. Do you, or do you plan to dive for pay? ☐ Yes ☐ No If "Yes", give details.

- Hang kite gliding
- Mountain climbing
- Rodeo
- Other

These sports require a special form from underwriting.

I represent that all statements on this form are true and complete to the best of my knowledge and belief. They are a part of my insurance application.

Matthew Stewart 8/14/13 Brian L Vik

Signature of Proposed Insured — Date — Signature of Licensed Agent/Broker/Representative

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Alcohol Questionnaire

Only one company is the issuer and responsible for obligations of any given policy.

Name of Proposed Insured: MATTHEW STEWART | Date of Birth: 3/20/1976 | File No.:

Please give a brief outline of your drinking history (describe how often and how much you drank): I USED TO DRINK AT PARTIES ON WEEKENDS

☐ Yes ☒ No Have you ever been treated at a Chemical Dependency Treatment Center or by a physician?

☐ Yes ☒ No Did you participate on a voluntary basis? Please give details: _____

Dates of treatment from _____ to _____. Dates if more than one time. _____

Name and address of treatment center: _____

Name and address of attending physician: _____

☐ Yes ☒ No Were you advised to continue outpatient counseling? If yes, did you continue as an outpatient?

If yes, from _____ to _____. Name and address of facility or doctor _____

Date of last drink: 4/21/2008

☐ Yes ☒ No Are you a member of AA? If yes, how long? _____

If you joined and left, and rejoined AA, provide details: _____

How often do you attend AA meetings? _____

☐ Yes ☒ No Do you use antabuse, sedatives or tranquilizers? If yes, what and how often? _____

Name and address of physician prescribing drugs: _____

☐ Yes ☒ No Were there any unusual circumstances surrounding your drinking habits? If yes, give details:

☐ Yes ☒ No Is there any physical or psychological impairment as either a cause or effect of drinking?

If yes give details: _____

☐ Yes ☒ No Is there any motor vehicle record as a result of drinking? If yes, give details: _____

☐ Yes ☒ No Was your license suspended? If yes, from (date) _____ to (date) _____

☐ Yes ☒ No Were you required by your state to attend any type of driving school or alcohol abuse classes?

If yes, what dates: _____

☐ Yes ☐ No If you attended these classes, is your motor vehicle record cleared of the charges? N/A

I represent that these statements are true and complete.

[signature] x 08/23/13
Signature of Proposed Insured — Date MM/DD/YYYY

MATTHEW STEWART
Print Name

Signature of Witness (Agent/Broker)

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Financial Underwriting Supplement for Life Insurance

1. Proposed Insured 1 (First, Middle, Last)	Proposed Insured 2 (if Survivorship)
MATTHEW CLARENCE STEWART	
Name of Owner(s)	**Amount of Insurance**
MATTHEW CLARENCE STEWART	$ 2,000,000

2. **Explain how the amount of coverage was determined.**
TO PAY OF HOME + BUSENESS DEBT SO FAMILY CAN NOT HAVE TO DEAL WITH IT

3. **Purpose of Insurance** (select all that apply):
☒ Income Replacement ☒ Final Expenses ☒ Estate Liquidity ☒ Debt Protection ☐ Charitable Giving
☐ Other: _____

4. Income	Insured 1 Last Year	Insured 1 Prior Year	Insured 2 Last Year	Insured 2 Prior Year
Annual Salary	$ 140,000	$ 120,000	$	$
Dividends	$ —	$	$	$
Investment Income	$ —	$	$	$
Pension/Retirement Income	$ —	$	$	$
Social Security	$ 0	$	$	$
Undistributed Profits	$ —	$	$	$
Other	$ —	$	$	$
Total	$ 140,000	$ 120,000	$	$

5. **Net Worth**
Please provide a complete accounting of assets and liabilities. See additional instructions at the end of the form about providing third party verification using this form, or what other forms of third party verification are accepted. If other forms of verification are being provided, you may skip to Question 6.

Assets:		Liabilities	
Cash (Checking/Savings Accounts)	$ 130,000	Mortgages	$ 400,000
Notes Receivable	$ 80,000	Loans	0 $ ~~400,000~~
Accounts Receivable	$ 100000	Notes Payable	$ 40,000
Real Estate	$ 550,000	Accounts Payable	$ —
Investment Accounts	$ —	Business Debt	$ NONE
Business Interest	$ 500,000	Taxes	$ NONE
Personal Property (art, jewelry, etc)	$ 70,000	Other Liabilities	$
Life Insurance Cash Value	$ —		
Retirement Accounts	$ —	**Total Liabilities:**	$
Other Assets	$		
Total Assets:	$ 1,300,000	**Net Worth:**	$ 860,000

6. **Premium Funding**
a) What is the planned source of the funding for the policy(ies) currently applied for?
☒ Income ☐ Premium financing – provide detail in Section 8 ☐ Prior settlement
☐ Asset liquidation, list assets to be liquidated: _____
☐ Other, please list: _____

b) Has any party, other than the Proposed Owner or Proposed Insured offered to provide any funding or payment in exchange for any right, title or other interest in any policy issued on the life of the Proposed Life Insured(s) as a result of this application? ☐ Yes ☒ No If yes, provide details: _____

c) Will the Owner, now or in the future, be paying premiums funded by an individual and/or an entity other than the Proposed Life Insured(s), or the Proposed Life Insured's employer? ☐ Yes ☒ No

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Financial Underwriting Supplement for Life Insurance

7. Settlement

a) Will any policy issued on the life of the Proposed Insured(s) as a result of this application replace a policy(ies) which has been viaticated or settled? ☐ Yes ☒ No If Yes, complete 7b. For multiple policies, provide answers to questions 7b-h on a separate page with the Proposed Insureds' name, witnessed, signed and dated.
b) Insurance Company: _____
c) Date of Issue: _____
d) Date Settled or Viaticated: _____
e) Amount received for settlement or viatication: _____
f) Reason for settlement or viatication: _____
g) What is the name of the Life Settlement Company? _____
h) Who received the settlement proceeds?
☐ Insured ☐ Policy Owner, list name: _____ ☐ Business, list name: _____

8. Premium Financing

If premium financing is being used, provide details of the premium finance arrangement below.
Please provide a copy of the premium finance term sheet.

a) What is the loan interest rate? _____ %
Interest is paid: ☐ annually ☐ accrued
b) In addition to repayment of principal and interest, are there other fees, charges or other consideration to be paid on maturity? ☐ Yes ☐ No If Yes, provide details: _____
c) What is the duration of the loan? _____
d) Who is the lender? _____
e) What collateral is required to secure the loan? Amount: $ _____
Type: _____
f) When will the loan be repaid? _____
g) How will the loan be repaid? _____

9. Life Expectancy

Will any entity other than a life insurance company be medically evaluating the Proposed Insured(s) to determine life expectancy? ☐ Yes ☒ No

Optional Third Party Verification

Third party verification must be provided by a disinterested person to the life insurance transaction. Acceptable forms of third party verification include an audited financial statement, current brokerage account statements, the most recent filed tax returns or loan documents.

Matt Stewart

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Signatures -- I represent that these statements are true and complete to the best of my knowledge and belief. They will become a part of my insurance application.

Signature of Proposed Insured 1	**Signature of Proposed Insured 2**
X Matt Stewart	X

Signature of Owner(s), if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.

Owner	Title
X	
Owner	Title
X	

Date	Signature of Licensed Agent/Broker/Representative	License Number
8-6-13	X	

Co-signature by resident Licensed Agent/Broker/Representative, if applicable in your state	Date	License Number
X		

Optional Third Party Verification

Third party verification of Proposed Insured's financial information may be provided by completion of the signature block below. Third party verification must be provided by a disinterested person to the life insurance transaction.

In lieu of the signed form other acceptable forms of third party verification include an audited financial statement, current brokerage account statements, the most recent filed tax returns or loan documents.

Signature of Accountant/Attorney/Financial Advisor	Date
X	

Accountant/Attorney/Financial Advisor Name (Printed)	Length of time known Proposed Insured(s)

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Financial Underwriting Supplement for Life Insurance

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Quest. #	Include additional details as requested, and specify Proposed Insured's name.

Signature of Proposed Insured	Date	Signature of Witness/Title
X		X

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Amendment and Acceptance Form

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

CAUTION: The Policy listed below (or a requested adjustment or reinstatement thereof) will not become effective unless this form is signed as required below. This form (and any Rider Forms requiring the policyowner's signature) must be returned to the Home Office fully signed and dated, or the Policy returned for cancellation.

Policy No. 4751596 Insured: Matthew Clarence Stewart

The above-identified Policy is issued (or adjusted or reinstated, as applicable) by the Company and accepted by the Policyowner subject to the following terms, provisions or amendments:

With Annual premium amount changed to $1,355.14.

By signing below, I agree that any amendments to the Application listed above are part of the Application, and the Application and the amendments are to be taken as a whole. It is agreed that the above Policy is issued (or adjusted or reinstated, as applicable) on the basis of the statements in the Application and in this Amendment and Acceptance Form.

To be signed and dated by the person(s) indicated below:

☐ Policyowner: _____ ☐ Insured: _____

Date: 10/7/13

AA 974 N

Principal Financial Group

Principal National Life Insurance Company

ACKNOWLEDGMENT
OF DELIVERY

September 8, 2013

RE: POLICY 4751596

We are happy to welcome you to Principal Financial Group. Please sign the form below acknowledging that you have received your policy. If you have any questions after reviewing your policy, please contact your financial representative.

Acknowledgment is given that policy 4751596 has been delivered to me today, and is based on the life of Matthew Clarence Stewart.

Signature of:

Matthew Clarence Stewart — Date: 10/7/13

TERM LIFE INSURANCE POLICY. Benefits payable at the death of the Insured prior to the Policy Expiration Date and while the policy is in force. Renewal premiums payable during continuance of the policy. There is a Conversion Privilege as described in the policy. This policy is non-participating.